Dental Claim Form

©American Dental Association, 1999 Version 2000 1. □Dentist's pre-treatment estimate Specialty (see backside) 3. Carrier Name																		
	Der	ntist's stateme	ent of actual se	ervices														
□ EPSDT -							4. Carrier Addr							1	т			
							5. City								6. Stat	ie	7. Zip	
							9. Address	9. Address				10. City						11. State
PATIENT							15. Phono Number			16 7	16. Zip Code							
	12. Date of Birth (MM/DD/YYYY) 13. Patient ID #						14. Sex □M □F			F	15. Phone Number				10.2	_,p		
	17		p to Subscribe				-	18. Employer/School										
	□Self □Spouse □Child □Other											NameAddress						
SUBSCRIBER / EMPLOYEE	19	9. Subs./Emp.	21. Group#				31. Is Patient covered by another plan						32. Polic	y #				
	22. Subscriber/Employee Name (Last, First, Middle)									នួ	□No (Skip 32–37) □Yes: □Dental or □ Medical 33. Other Subscriber's Name							
	22	2. Subscriber/		Policies			55. Other Supschipers realine											
	23. Address				24. Phone Number			ER P.	34. Date of Birth (MM/DD/YYYY) 35. Sex 36. Plan/Program Name						am Name			
	25. City			(2/4)	26	27. Zip Code	OTHER		OTH.	/ / DM LJ 37. Employer/School				<u>J</u> F				
	25. 5.0			المال	D)11 1				1		NameAddress				ess			
	28. Date of Birth (MM/DD/YYYY) 29. Marital Status					30. Sex				38. Subscriber/Employee Status								
	/ Married Single C 39. I have been informed of the treatment plan and associated fees. I						agree to be responsible for all				□ Employed □ Part-time Status □ Full-time Student □ Part-time Student 40. Employer/School							
	charges for dental services and materials not paid by my dental bene						int plan, unless the treating irohibiting all or a portion of such				NameAddress							
	cl	harges. To the this claim.	e extent permit	ıthorize rele	ease of any information relating			,	41. I hereby authorize payment of the dental benefits below named dental entity.				otherwise payable to me directly to the					
	×	(x						_			
	Signed (Patient/Guardian) Date						(MM/DD/YYYY)				Signed (Employee/subscriber)				Date (MM/DD/YYYY)			
BILLING DENTIST	42. Name of Billing Dentist or Dental Entity								Phone N	Numb	er	44. Provider ID #			45. Den	45. Dentist Soc. Sec. or T.I.N.		
	46. Address						47. Dentist Lice			Licen	se # 48. First visit date of current			urrent	49. Place of treatment			
											series:			□Office □Hosp. □ECF □Other nent for orthodontics? □Yes □No				
	50. City 51. State 52. Zip						Zip Code	Zip Code 53. Radiographs ☐Yes, How mar							ice already commenced:			
	55. If prosthesis (crown, bridge, dentures), is this If no, reason for										· — — _			Date applia	iances placed Total mos. of treatment			
B	initial placement? ☐Yes ☐No								I- 4 t								remaining	J
	56. Is treatment result of occupational illness or injury? ☐No ☐ Yes Brief description and dates							57. Is treatment r Brief description				result of: □auto accident? □other accident? □neither and dates					_	
58. [1	Diag	nosis Code Ir	ndex (optional) 2	3.		4	I		5			6	7		8			
59. E	xar	nination and t		s – List teeth in o					- T		Description				Fee	{	Adm	in. Use Only
Dat	e (M	(MM/DD/YYYY) Tooth Surface			Diagnosis Index #		Procedure Coo	de Qty			Description			1.00				
<u> </u>	-			• • • •		11.11		\dashv										
\vdash	-				-		<u>Leimaine</u>	-	\dashv									
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	-																	
													·			[
				N. W. SVI														
60. I	60. Identify all missing teeth with "X" Permanent											rimary Total Fee						
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 A B C D										- +	FGHI		Payment by other	olan		\dashv		
	32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 T S R Q P 61. Remarks for unusual services												Deductible			\dashv		
												Carrier %						
1												Carrier pays						
												F	Patient pays					
62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those												63. Ad	dress where treatr	nent was perf	ormed			
have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.									- 3-	64. City 65.State			ate	66. Zip Code				
X Signed (Treating Dentist) License # Date (MM/DD/YYYY)																		